



WITNESS STATEMENT

[Form RM-04]

Rev. 12/2009

The statement of a(n):

- STUDENT
- EMPLOYEE
- VOLUNTEER
- VISITOR
- Other:

WITNESS INFO	NAME:	DRIVERS LICENSE NUMBER:	D/L ISSUING STATE:
	STREET NUMBER:	WORK PHONE:	
	CITY, STATE and ZIP:	HOME PHONE:	

LOCATION of INCIDENT (i.e. address, particular part of the building, etc. – include as much detail as possible)

WHERE WERE **YOU** in RELATION to the INCIDENT WHEN it OCCURRED?

DATE:	TIME: AM / PM	WAS ANYONE INJURED in THIS INCIDENT?: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN
-------	---------------	---

NAME of INJURED PARTY: (if applicable)	TYPE of INJURY IF KNOWN:
--	--------------------------

DO YOU PERSONALLY KNOW the INJURED or any INVOLVED PARTIES? <input type="checkbox"/> YES <input type="checkbox"/>	NAME of KNOWN PARTY (if appl.):	RELATIONSHIP (if appl.):
---	---------------------------------	--------------------------

DESCRIBE **HOW** the INCIDENT OCCURRED (include complete names of parties involved and make sketches, if appropriate):

SKETCH ON BACK

DESCRIBE ANY APPARENT **DAMAGE** to PROPERTY

IN YOUR OPINION WHAT WERE the **ROOT CAUSES** of the INCIDENT:

DISTRICT EMPLOYEE MOST FAMILIAR WITH THIS INCIDENT:	EMPLOYEE CONTACT PHONE:
---	-------------------------

FAX or E-MAIL a COPY of this completed form to **RISK MANAGEMENT** at: (510) 644-8881

FOR INFORMATION THAT WILL NOT FIT ON THIS FORM, PLEASE ATTACH ADDITIONAL SHEETS.

WITNESS NAME:	WITNESS SIGNATURE:	DATE:
INTERVIEWER's NAME (if appl.):	INTERVIEWER's SIGNATURE:	DATE: